

WITNESS FEE EXPENSE REIMBURSEMENT

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04 (1)(m)].

Witness on behalf of Impartial Hearing for the Division of Vocational Rehabilitation (DVR)

At: _____ Date: _____
(City Where Hearing Was Held)

To be reimbursed for witness fees, DVR needs the following information:

Name		
Address		
City & Zip Code		
Social Security Number		
Left Home	(Date)	(Time)
Total Miles Traveled to Attend Hearing (at \$0.20 per Mile)		

The Division of Vocational Rehabilitation will reimburse witnesses at \$16.00 (full day) or \$8.00 (half day), plus \$0.20 per mile. No reimbursement will be allowed for any other expenses incurred (i.e., meals).

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT.

Hearing Officer Name (Please Print)

Hearing Officer Signature

Date Signed

Form should be submitted to:

Impartial Hearing Coordinator
DVR Central Office
201 East Washington Avenue
Madison, WI 53707-7852